

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1731

Registration District No. 73 Primary Registration District No. 3006 Registrar's No. 18

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(c) Name of hospital or institution White Cavalier Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3
In this community Most of life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Oliver C. Roby

3. (b) If veteran, ☒ name war ✓ 3. (c) Social Security No. ✓

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, 2 divorced Widowed

6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased July, 28 - 1899
(Month) (Day) (Year)

8. AGE: Years 92 Months 5 Days 27 If less than one day hr. min.

9. Birthplace Wheeling, W. Va. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business ✓

12. Name Roby

13. Birthplace Virginia 1
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Taylor

15. Birthplace Virginia 1
(City, town, or county) (State or foreign country)

16. (a) Informant Carrie Boggs

(b) Address Rocheport, Mo.

17. (a) Burial (b) Date thereof 1-27-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rocheport Mo

18. (a) Signature of funeral director Partee (W.H.S.)

(b) Address Columbia Mo.

19. (a) 1/27/41 (b) Allie Selby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10
(c) City or town Columbia
(If outside city or town limits, write "RURAL")
(d) Street No. 104 Ripley St.
and Rocheport, Mo.
(e) If foreign born, how long in U. S. A. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25 year 1941 hour 8 minute 15 A. M.

21. I hereby certify that I attended the deceased from Jan 25 to Jan 25, 1941;
that I last saw him alive on Jan 20, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration

Due to Senility

Due to

Other conditions (Include pregnancy within 3 months of death) ✓

Major findings: Of operations ✓

Of autopsy ✓

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ✓

(b) Date of occurrence ✓

(c) Where did injury occur? ✓

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

While at work? 74 (Specify type of place)

(e) Means of injury ✓

23. Signature Raymond Simpson (M. D. or other) D

Address 506 Cherry St Columbia Date signed 1-26-41

RECEIVED
JAN 10 1922
DEPT. OF HEALTH
DIVISION

ALL

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

....., Registered Apprentice No.

working under my personal supervision.

Signed

W. H. Vandewater

Licensed Embalmer No.

2494

P. O. Address

Columbus, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 1731

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 18

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
White Convalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT
FULL NAME

Oliver C. Rees
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
92 5 27 hr. min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4/2/41 (b) Allie Selby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

20. DATE OF DEATH

Month Jan day 25 -
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death uremia
chronic nephritis
Due to senility

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Dr. Lloyd Simpson (M. D. or other) MO

Address Columbia MO Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

S-1731